Correspondence

Why Physicians Retire

TO THE EDITOR: The article on "Physicians' Adjustment to Retirement" in the February issue[1] misses the point. Show me one statement in the article that discusses the reasons physicians retire. Were the respondents reticent to reveal a reason, or were the authors avoiding exploring an obvious and deplorable reason?

There are many reasons physicians choose to retire: ambulatory difficulties, mental atrophy, loss of hearing or sight, and the like. The reason I found unconscionable, ruthless, and demeaning after 50 years in practice is the devastation of a noble profession into a meretricious business.

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REFERENCE

1. Virshup B, Coombs RH: Physicians' adjustment to retirement. West J Med 1993; 158:142-144

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Drs Virshup and Coombs Respond

TO THE EDITOR: Dr Tepper is concerned that we did not address the question of why physicians are retiring. We understand his position fully. We have written elsewhere that government intervention and control, skewed economic factors, and the emergence of health maintenance organizations (HMOs) have eroded medical ideals and ethics, physicians' sense of independence, and their sense of being special.[1] Medical employees of HMOs become gatekeepers, pushed to see more and more patients daily. Further stress has been added by the malignant threat of malpractice suits.

We agree with Dr Tepper that this is a climate in which many physicians are choosing to leave medicine and that we did not address this in our article.[2] What we did address was the fear of retirement itself. That, at least, we can deal with here—we and many others have been there. When the "whips and scorns" of practice become too great, retirement need not be viewed with alarm.

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A Fatal Case of Pulmonary Hemorrhage From Thoracentesis

TO THE EDITOR: Thoracentesis is frequently performed at the bedside and is generally considered to be "relatively uncomplicated technically, well-tolerated and quite safe."[1] We report a case that illustrates the danger of thoracentesis.

Report of a Case

The patient, a 96-year-old man, was admitted for cough and fever. He had been treated for pneumonia two weeks earlier at another hospital, but his symptoms failed to resolve. He had no history of abnormal bleeding. On admission his temperature was 38°C (101.3°F); examination elicited dullness to percussion and decreased breath sounds at the left base.

The patient had a leukocyte count of 6.5×10^9 per liter (0.87 neutrophils), a hemoglobin of 130 grams per liter, and a platelet count of 442×10^9 per liter. A chest x-ray film showed a right lower lobe infiltrate and a large left-sided pleural effusion that layered on the decubitus x-ray film.

He was admitted to hospital and remained febrile despite the intravenous administration of antibiotics. On the second hospital day, a left thoracentesis was done by a first-year and a third-year house officer. The effusion was percussed, and a 22-gauge needle was inserted 2 cm below the tip of the left scapula. No fluid was obtained, and the catheter-through-the-needle system was introduced into the same interspace. The catheter was advanced, again with no fluid collected. The procedure was halted and the patient placed back in bed. About three minutes later, the patient began to have gross hemoptysis and became unresponsive. Despite vigorous resuscitative measures, he died.

Postmortem examination revealed blood occluding the left main-stem bronchus and most of the proximal airways of the left lung as well as in the right main-stem bronchus and right lung; a 400-ml left hemothorax; two puncture marks on the posterior surface of the left lung; gross consolidation of the lower lung fields bilaterally; and a fibrinous exudate covering the left posterior lower aspect of the lung. The cause of death was recorded as hemoptysis due to needle puncture of the left lung during thoracentesis.

Discussion

In four prospective studies of thoracentesis involving a total of 404 patients in teaching hospitals, the incidence of pneumothorax ranged from 11% to 19% and of "dry tap" from 6% to 13%.[2-5] Serious complications such as splenic laceration, sheared-off catheter, and pneumohemothorax also occurred but were uncommon. Although many articles discuss dry taps and the use of the catheter-through-the-needle technique, we find only one other case of pulmonary hemorrhage as a complication of thoracentesis in the medical literature.[6] This involved a patient with dialysis-dependent renal failure, pneumonia, and a thoracentesis done with a 20-gauge spinal needle.

Our patient died of massive intrapulmonary hemorrhage due to catheter placement during a "dry tap." The risks and benefits of thoracentesis should be weighed carefully in each patient. Experienced personnel should supervise the procedure, and the catheter-through-the-

needle system should be used for therapeutic but not diagnostic procedures. The catheter should never be inserted if fluid is not obtained first with a conventional needle. Ultrasound guidance should be used in any difficult case and has been shown in one study to reduce the complication rate substantially.[5]

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No Time to Listen and Talk to Patients

TO THE EDITOR: The article by Lester and Smith, "Listening and Talking to Patients—A Remedy for Malpractice Suits?" in the March issue examines the way physicians communicate with patients and how good communication seems to improve the physician-patient relationship, making malpractice suits less likely.[1] What is not included in this article, but what must also be made clear, is the effect that the current reimbursement climate has on the physician-patient relationship. For those of us in private practice, reimbursement continues to be cut. Physicians are forced to see more patients. If the physician extends office hours to do so, this will certainly increase fatigue and affect the manner in which physicians interact with patients. For those whose office hours are already set to the limit, more patients will have to be seen in the same amount of time, affording less time for each patient.

New payment policies based on revised American Medical Association Evaluation and Management Codes specify that services are to be "problem-focused." Whereas in the past physicians have cultivated their relationships with patients by sometimes spending time in what might be construed as idle chatter, this now becomes a waste of potentially important, income-related time.

Some might say that, regardless of payment regulations, physicians are still expected to establish the same relationships with patients that they had 20 years ago. I, on the other hand, think it is more realistic to note that society's obligation toward physicians has certainly changed over the past 20 years, and it is only logical to expect the physician-patient relationship to change as well.

Perhaps we may read in the future how the nurse practitioner or physician assistant's interaction with patients is important in avoiding lawsuits, because I foresee managed care experts realizing that these health care workers are a lot cheaper to employ as gatekeepers than are physicians.

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1. Lester GW, Smith SG: Listening and talking to patients—A remedy for malpractice suits? West J Med 1993; 158:268-272

The Editors are pleased to receive letters commenting on articles published in the journal in the past six months, as well as information or short case reports of interest to our readers. ALL MATERIAL SUBMITTED FOR CONSIDERATION MUST BE DOUBLE-SPACED. Letters NO LONGER THAN 500 WORDS are preferred. An original typescript and one copy should be submitted. All letters are published at the discretion of the Editors and subject to appropriate editing. Those of a scientific nature will be peer reviewed. Authors should include information regarding conflict of interest, when appropriate ("I warrant that I have no financial interest in the drugs, devices, or procedures described in this letter"). Most letters regarding a previously published article will be sent to the authors of the article for comment. Authors of accepted letters will have an opportunity to review the edited version before publication.